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Modern and Humane Treatment

OF THE

MORPHINE DISEASE.

—BY—

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Obersteiner, the eminent Austrian alienist, writing, in 1883, of the morphine disease, declared: "Quite an incredible number of our colleagues have fallen victims to it, and many have only just escaped." History has repeated itself along this line, during the last decade, with startling and sorrowful frequency, and the end is not yet; for it is a well recognized fact, which my experience fully and increasingly attests, that among our own profession, morphinism finds its favorite victims. Granting this, no apology is needed for bringing this trite—to many, it may be—topic before a congress of medical men, some of whom have, it is safe to say, a more or less direct, personal, perchance painful, interest in the question it involves.

For nearly one-third of a century, this disease has had a place on the list of toxic neuroses. During many of these years it was added to largely—almost wholly—by the favorite form of subcutaneous medication; a method facile, yet often fatal, but which, happily, is now, in my opinion, decidedly on the decline. While felicitating ourselves that the progress of this destroyer is less rapid than in days agone, we cannot ignore the fact that it is still with us, and that whatever holds out the promise of undoing the mischief it has done; whatever gives assurance of ending, or even lessening, the ruin it has wrought, must have a claim upon our interest, and make worthy the best effort at our command.

It is now nearing a quarter century since a case of this disease first came to my care. For most of these years my attention has been exclusively devoted to its study and cure, with a result that warrants me in asserting at no time has the treatment been so simple, satisfactory, and successful, as now.

The modern and humane treatment of the morphine disease—pre-eminently an American plan—is compassed, mainly, by three drugs—bromide of sodium, codeine, and trional. These

form a combination of unrivaled value if properly used, in proper cases, and, with certain minor aids, make a method far in advance of any yet presented to accomplish two leading objects —minimum duration of treatment, and maximum freedom from pain.

In 1876 the attention of the profession was invited by the writer, to a new application of the well-known power of the bromides to subdue reflex nervous irritation, by commending the use of bromide of sodium in this disease, after a plan quite original, which consisted in giving it, in gradually increasing amount, often enough to secure the effect of a continuous dose, for six to ten days, during which time the habitual opiate was to be gradually, but entirely, withdrawn; the object being to secure, by this preliminary sedation, a maximum sedative influence from the bromide at the time of maximum nervous irritation from the opiate-ending.

This, too, was the origin of what is known as the "rapid method," and history will attest the writer's claim to whatever of merit it may have, though, by many, it has been placed mistakenly to the credit of a foreign physician. This plan, a mean between two extremes, avoiding the painful ordeal of abrupt disuse, and the tiresome delay of prolonged decrease, was correct in theory, and in practice proved a success.

The preliminary sedation feature of this method consists in giving the bromide of sodium in initial doses of 30 grains, twice daily, at 10 A. M. and 10 P. M., and increasing this dose 10 grs. each day, *i.e.*, 30, 40, 50, 60, etc., until a maximum of 100 grs. semi-daily, is reached on the eighth day. On the ninth and tenth days, this maximum 100-grain dose is given in the evening only.

This giving of the bromide applies solely to typically eligible cases. With some it is clearly contra-indicated; with others, a minor degree of preliminary sedation will suffice; and with all patients this rule governs: *Each case is a law unto itself, and the length and amount of the bromide giving, and consequent rate of opiate decrease, is determined entirely by individual peculiarity, as shown both before and during treatment.* This must not be forgotten; brains must be mixed with the bromide. This is a point of prime importance, and failure to put it in practice will account for ill success.

Of the value of the bromide thus given, to counteract and control the nervous symptoms usually incident to the morphine

ending, there is no question; and it is the absence of this special feature that makes the Erlenmeyer plan, which is complete opiate quitting in two to ten days, inferior to the method we commend.

During this time of bromidal medication, no other treatment is called for, usually, save a tonic regimen, and such regulation of gastric, renal, and alvine functions as each case may seem to demand, in this respect being markedly and favorably in contrast with any method that does not include preliminary sedation, and which makes essential various anodynes, sedatives, stimulants, and hypnotics during the opiate decrease, if the patient's comfort be conserved. For full details of this opiate-quitting régime, see paper by the writer, "The Mattison Method in Morphinism."

Having secured the desired sedation and reached the end of the morphine-taking, whatever reflex symptoms present are met, mainly, by codeine. This is the second special factor in the modern treatment of morphinism. And it is no excess of assertion to declare that it has revolutionized the therapeutics of this disease. With it, the ordeal of quitting a long-used opiate is robbed of its terrors, and it comes nearer to making a "royal road" to freedom for the captive morphinist than anything now at command.

Of this therapeutical triad, codeine is the most important, for it can be used with good in all cases, whereas some will present in which the bromide should not or need not be employed, nor is trional essential.

Codeine may be given pure, or in either of three salts—phosphate, muriate, or sulphate. Pure codeine is not fitted for subdermic use. It dissolves with acid and may be given by mouth. Of the salts, the muriate and phosphate are richest in codeine—eighty and seventy-six per cent.—and the phosphate is freely soluble. My usual solution is six grains to the drachm. The sulphate dissolved in boiling water, two grains to the drachm. The dose should be one to three grains, by mouth or skin, every two to four hours, according to case or condition, and continued in gradually decreasing dose and increasing interval till no longer required. The dose by stomach should be double that by skin. As a rule, codeine is not called for till after the entire morphine-quitting. If needed earlier, it should be given.

Cases will present in which the bromide need not, or should not, be used. In these codeine, with, may be, some hypnotic, a few nights, will serve every purpose.

The credit of first commending codeine in morphinism belongs to an American physician—Lindenberger, of California; who, in 1885, claimed for it merit after a method of his own. Later, Schmidt, Fischer, and Rosenthal, abroad, asserted its value, and my own experience, large and enlarging, makes me regard it my most valued aid.

For larger details along this line, *vide* the writer's paper, "Codeine in the Treatment of the Morphine Disease;" reprint if desired.

The third factor in this modern method is trional. Of hypnotics this is the latest, and, in treating narcotic habitués, the greatest. There is no doubt of this. I have given it hundreds of times, and say whereof I know. It is better than sulphonal —its nearest rival, and which, till the advent of trional, led the list of hypnotics in this condition—having an effect more certain, pronounced, and prolonged. My usual dose is forty grains for males, and thirty for women, given dry on tongue at 7 P. M., after the last morphine-giving. It is largely soluble in hot water, milk, soup, or tea, and thus taken acts quite promptly. It is not only *the* soporific in these cases, but is markedly sedative, and so serves doubly for good. We use it exclusively during the first six or eight nights, decreasing it gradually to half the initial dose, and then, if needed, resort to chloral, paraldehyde, or cannabis. Some cases do not require it. One of the most striking ever under my care, has done notably well without it, codeine phosphate having secured several hours' sleep each night. My opinion, steadily growing, of trional in the insomnia of morphine habitués, is that it is the most valuable soporific we now possess. See my papers, "Trional, the New Hypnotic; its use in Narcotic Habitués," and "Trional;" reprints on request.

Such are the main measures in the modern treatment of the morphine disease. Minor symptoms along various lines will, at times, present, to be met, as they can be, and effectively, as they seem to demand. Treatment must needs be varied, as case requires. The patient, as well as his disease, must be treated. Details need not detain us. They are at command of any who desire, in the paper first cited: "The Mattison Method in Morphinism."

Regarding humane treatment, a brief statement of fact, and this paper is ended. In 1879, Levenstein presented his "Morbid Craving for Morphia," a book valuable along some lines,

but harrowing in its gruesome tale of suffering incident to his plan of treatment. Since then this method—abrupt and entire disuse—has found favor with some medical men, who, from ignorance or disregard of distress, either of which is without excuse, have been led to commend it. These men, misguided and mistaken, may mean well; but they fail to appreciate the sorrow their counsel entails, and it is safe to say, were they forced to run the gauntlet of such suffering, were they bound to the rack of such torture, there would be a rapid and radical change of opinion.

"Levenstein's grim tale, cold and terse as a hardware catalogue, of the tortures through which the patient passes—the days and nights of writhing, the sleeplessness, the restlessness, the thirst, the endless vomiting and purgings; his vain pleadings for liberty, for morphia, for anything which will relieve the intolerable anguish—are fairly burning with their burden of tragedy!"

In 1883, an American physician, T. L. Papin, said: "Suppose your patient is habituated to morphia, how will you cure him? Let him quit short, absolutely, and entirely. If he have the will-power, trust him; if he cheats, lock him up; put a Hercules over him as a nurse. All substitutes are simply a prolongation of the agony he must go through. The patient who quits morphia suffers from insomnia, diarrhœa, nausea, vomiting, achings, and debility to such a degree that it is a marvel how he lives. All this suffering will last five to ten days. No medicine will do any good; the stomach rejects everything—even a mouthful of cold water. At last, after several centuries of torture, little by little, and without medicine or substitutes, nature accomplishes the cure. This terrible treatment, I am sure, is not only the best, but the only safe one to cure and secure the patient against a relapse."

Well may one stand amazed and aghast at the "cruelty" of such "ignorance," and well may Bartholow declare: "Having had one experience of this kind, I shall not be induced to repeat it; if for no other, for strictly humanitarian reasons, since the mental and physical sufferings are truly horrible."

In 1888, a teacher in one of our leading medical schools—J. C. Wilson, University of Pennsylvania—in a clinical lecture, commended this treatment: "The patient is put to bed, and the physician administers the drug hypodermically. During the first twenty-four hours the dose should be that he is in the habit

of taking. The next day the dose should be diminished one-half. The following day it should again be diminished one-half, and by the fourth day the dose may be entirely stopped. As soon as the physical effects of the morphia which has been taken pass off, there is relaxation of the vaso-motor system of the intestinal tract, with a pouring out of fluid into the intestines and stomach, with copious vomiting and free diarrhœa, often colliquative. There is intense craving for the drug. There is marked nausea and inability to take food. There is complete sleeplessness, and, sooner or later, delirium appears, and this is often attended with tremor. Finally, the delirium may become intense and active, and during this period there is danger of sudden heart failure and collapse, which in some cases have proved fatal.

"With reference to the necessity for this sort of treatment, it may be said that it is desirable to undertake it in every instance where you can prevail upon the patient and his friends to submit to it. It is not without much suffering and some danger. There are cases in which, from heart failure, the danger to life is so great, you must abandon the attempt."

Sorry, indeed, the lot of a hapless morphinist under the care of any physician so lacking in skill or feeling as such counsel implies; and, verily, a teacher like that has mistaken his calling along this line, and should limit himself to a field in which larger knowledge and broader experience give his counsel greater weight.

In 1893 another American doctor, E. P. Hurd, in a paper on "The Erlenmeyer Treatment," wrote: "The method contemplates and seriously attempts the entire withdrawal of morphine in about a week, the daily dose being first cut down one-fifth, then two-fifths, then three-fifths, then four-fifths, and so on till none is given. *During the period of withdrawal* (italics mine) the place of the morphine is supplied by various stimulants, narcotics, and hypnotics. It may be necessary during the first week to give large quantities of whiskey, almost to intoxication; chloral and sulphonal in large doses; quinine and strychnine will also be needed to meet indications. After the last dose of morphine has been given, the patient will be in a condition of great depression, and powerful stimulation will be required for a few days; sometimes diarrhœa or collapse will indicate the necessity of a temporary resort to morphine or to deodorized laudanum. Then, when the patient is sufficiently

weaned from morphine, the task is begun of weaning him from the drugs and from the alcohol by a tapering-off plan, which will require about three weeks. Naturally, it is a month of anxiety to the physician, and of trial and suffering to the patient."

What a travesty on rational therapeutics! If such be the "Erlenmeyer treatment," the less of it the better. In justice to this eminent German physician, whom I personally know, I am bound to say I do not accept it as his method.

Modern medicine has done much for humane relief of the hapless morphinist, but that ignorance of this advance still obtains, the following extract from a letter recently sent me by the writer last cited—Hurd—will well attest. He wrote: "If you, or any other man, or an angel from heaven, were to tell me that the morphia 'habit' could be cured without great physical suffering, I would reply that this is intrinsically and scientifically improbable!" What presumption this, in the face of his further statement: "I am free to confess myself only a novice and learner, and have not yet passed beyond the state of tentative experimentation for that of positive and scientific certainty." Let me assure this gentleman, and all other like skeptics, that the time of "tentative experimentation" in the therapeutics of the morphine disease, has *gone;* the day of "positive and scientific certainty" has *come.*

The Levenstein method is crude in theory and cruel in practice. It is brutal, utterly unworthy a healing art, and needs only to be described to be denounced. It incurs the risk of a fatal ending, has killed more than the world will ever know, and brought many perilously near to death. It has no claim to merit, either in abridging treatment or preventing relapse. Jennings truly says: "Dreadful as are the tortures inflicted, they do not, as a matter of fact, afford any safeguard against relapse." Most of Levenstein's patients had return of the disease, "notwithstanding the unwarrantable tortures to which they were subjected."

No valid excuse can be offered for its practice, save in rare cases, where conditions are peculiar and quite beyond control; and any physician so ignorant or inhuman as to counsel and compel it, except under such conditions, deserves to be made defendant in a suit for malpractice. The Erlenmeyer method, while less distressing and disastrous than the Levenstein, entails much suffering that can be avoided. It has no special merit as

effecting rapid or radical cure, and does not, in any way, well compare with the humane method we commend.

Quite apart from the merit of this humane method on the score of humanity, it has another bearing which is far-reaching and important. There can be no question that the dread of such suffering as attends the largely held idea of escape from the thraldom of morphia, is a decided bar to many an effort in this regard. Many think escape only possible through prolonged distress, and, despite a consummation devoutly wished, prefer to bear the ills they have. A notable case in proof is recalled. Fifteen years ago, a naval surgeon, three years a hypodermic morphia taker, first consulted me. Six years later he came to my care, and avowed the reason of his delay was the reading of Levenstein's book, and fear of such suffering as that treatment entailed. This gentleman made a surprisingly good recovery, was dismissed on the thirty-second day, and has remained nine years well.

When the practice of this humane method more largely obtains, we shall notice a steady increase in the number of ex-poppy habitués.

Mr. Chairman, this paper is a plea for merciful measures, to release from a galling bondage—made such by force of conditions beyond control—many who are deserving of deep commiseration. These measures are surely at command, and the medical man who does not, or will not, so acquaint himself, had best consign such cases to other care. Few advances in modern therapeutics have been more marked than the one to which we refer; and the writer is both glad and grateful that it has been his privilege to proffer humane help to many bearing the grievous burden of this phase of human ill.

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